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Complying with CHIPRA PPS Requirements for Services Provided by FQHCs/RHCs: Background and Options

INTRODUCTION

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) includes a provision that changes the way in which Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are reimbursed for services they provide to Children's Health Insurance Program (CHIP) subscribers. While there is no requirement in CHIPRA that states must contract with FQHCs/RHCs for services to their CHIP subscribers, CHIPRA Section 503 requires the application of Medicaid's prospective payment system (PPS) for states that choose to do so. CHIPRA also provides $5 million for state grants for expenditures related to implementing this provision. (Please see Attachment A for the language of Section 503.)

The purpose of this issue brief is to (1) identify for the Managed Risk Medical Insurance Board (Board) options for complying with the CHIPRA requirement to implement PPS for services provided by FQHCs/RHCs; and (2) seek Board guidance as to which option MRMIB staff should pursue in its discussions with the Administration, state Legislature, and stakeholders about implementing this provision.

Impact on HFP

Currently, MRMIB contracts solely with managed care organizations (MCOs), which in turn contract with providers for services to Healthy Families Program (HFP) subscribers. Complying with CHIPRA Section 503 will require a change in how MRMIB reimburses services provided by FQHCs/RHCs. It will also increase state costs and could have implications for HFP rate negotiations.

BACKGROUND

Federally Qualified Health Centers and Rural Health Clinics

Community health centers were first funded by the federal government in the 1960s. According to the National Academy for State Health Policy (NASHP), they share two key characteristics: (1) they maintain an "open door" policy, providing services to patients regardless of their ability

to pay; and (2) a significant proportion of their patient mix is uninsured or in the Medicaid program. There is a diverse array of community health centers, including migrant health centers, rural health centers and homeless health centers. All community health centers, or FQHCs, are either free-standing, nonprofit entities or county or public hospital affiliated. There are also "FQHC look-alike" clinics, which resemble FQHCs but do not receive federal "330 grant" funding.

NASHP reports that in 2007, 110 FQHCs with a total of 796 delivery sites served more than 2.3 million patients in California. Approximately 75 percent of these patients had incomes below 100 percent of the federal poverty level (FPL) and well over half were Hispanic/Latino. Medi-Cal, which provided FQHCs with over $1 billion in funding in 2007, is essential to the financial operations of these clinics. FQHCs in California see significantly more uninsured patients (45 percent of their total patients) than FQHCs in other states (39 percent).

Unlike FQHCs, RHCs can be not-for-profit or for-profit entities. They can be free-standing or hospital-affiliated. According to the California Primary Care Association (CPCA), there are about 260 RHCs in the state (20 licensed as primary care clinics, 120 that are hospital-affiliated, and 120 that are privately owned by physicians or nurse practitioners).

Medi-Cal Implementation of PPS

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2001 (BIPA) required Medi-Cal to implement a PPS reimbursement approach for FQHCs/RHCs. In theory, the PPS approach gave providers a financial incentive to operate efficiently by establishing a per-visit payment rate in advance based on the historical, reasonable costs of each clinic. (Medi-Cal Medical Care Statistics Section, June 2007) Although implementation was delayed for several years, state statute passed in 2003 (SB 36, Chapter 527, Statutes of 2003) requiring Medi-Cal to reimburse FQHCs/RHCs on a PPS basis, consistent with federal law. The Medi-Cal PPS rate, which is clinic-specific, includes fixed overhead and infrastructure costs as well as payment for services such as education, translation and transportation. Earlier legislation passed in 1998 (SB 1194; Chapter 894, Statutes of 1998) already required MCOs contracting with FQHCs/RHCs for services to Medi-Cal patients to contract with these clinics under the same terms and conditions as they do with other providers. Chapter 527 also authorizes an alternative payment methodology to calculate the PPS rate, and allows for adjustments in the PPS rate for changes in the scope of services provided by a FQHC or RHC. The base PPS rate is also adjusted annually by the Medicare Economic Index. (Please see Attachment C for the Code sections implementing PPS in Medi-Cal.)

Each year, participating managed care plans negotiate a reimbursement rate with each FQHC/RHC. These rates are required by law to be similar to rates paid to similar providers. The Department of Health Care Services (DHCS) then pays each clinic an interim, clinic-specific

"wrap-around"[1] payment for each encounter, based on the average of all plan payments the clinic receives per encounter. This supplemental payment represents an estimate of how much is required to fully reimburse clinics for their services pursuant to PPS. Once a year DHCS reconciles and adjusts FQHC/RHC payments as needed to reimburse them fully for their costs based on information provided by the FQHC or RHC. DHCS also conducts audits on the data provided; however, their primary focus has been with the front-end payments. According to CPCA, the average per encounter PPS rate paid to FQHCs in 2008 was $130, with county and public hospital FQHCs and Indian clinics receiving significantly higher rates. However, both utilization and wrap-around expenditures vary considerably among the twenty-two managed care Medi-Cal counties. (Medi-Cal Medical Care Statistics Section, June 2007)

The change in 2003 to a PPS reimbursement approach for services provided to Medi-Cal patients has provided a significant source of increased revenue for FQHCs/RHCs. The DHCS estimates that the managed care "wrap-around" payment to FQHCs/RHCs comprised just under 26 percent of total Medi-Cal payments to these clinics, and were 75percent greater in 2005-06 than in 2001-02. According to DHCS, "The FQHC wrap-around PMPM (per member per month) expenditures have been rising among beneficiaries enrolled in managed care plans as contracting health plans make greater use of FQHCs as network providers." Generally, counties that contain Health Professional Shortage Areas experience the highest FQHC/RHC utilization rates. (Medi-Cal Medical Care Statistics Section, June 2007)

Current Connections between the HFP and FQHCs/RHCs

In 2008-09, HFP plans contracted with FQHCs/RHCs providing coverage to HFP subscribers in 52 counties. (Six counties do not currently have any FQHCs/RHCs for plans to contract with). (MRMIB data) According to NASHP, only a small percentage of California FQHCs' operating revenue (about 2percent) is currently derived from their HFP subscribers. This may be because, despite contracts with MCOs representing HFP subscribers in most parts of the state, the overall size of the HFP subscriber population is dwarfed by the much larger number of Medi-Cal and uninsured patients seen by FQHCs/RHCs. In addition, the current reimbursement rates FQHCs/RHCs receive for services to HFP subscribers may be substantially below the PPS reimbursement rates they receive for Medi-Cal patients.

MRMIB has no information about the proportion of HFP subscribers who currently receive care from FQHCs/RHCs, nor does staff know the rates negotiated between MCOs and these clinics, as this information is not required to implement the HFP under its current managed care configuration. Informal discussions with several MCOs indicate that in some areas of the state, a significant amount of care received by HFP subscribers may be provided by FQHCs/RHCs.

[1] Under federal Medicaid statute, when a contract between a managed care organization and a FQHC/RHC results in the clinic receiving less than the amount of reimbursement due under the FQHC/RHC PPS, the state must make a supplemental "wrap-around" payment to the FQHC/RHC, to make up the difference the clinic is owed.

For example, the San Francisco Health Plan estimates that almost 50percent of its HFP subscribers receive their care from FQHCs.

Impact of ARRA

The American Recovery and Reinvestment Act of 2009 (ARRA) includes provisions that encourage and support the creation of additional FQHCs. Although organizations such as NASHP and the CPCA anticipate this will increase the number of clinics available to provide services to HFP subscribers in California, there is no specific information available at this time. However, according to a study done by the California Health Care Foundation in March 2009, the number of community clinic sites in the state increased from 596 to 762 between 2003 and 2006. The study attributes this growth at least in part to the increase in federal funding (including the change in Medi-Cal reimbursements to PPS for clinic services). If, as expected, the number of FQHCs/RHCs increases as a result of ARRA, their share of services to HFP subscribers may also be expected to increase, especially once the more favorable PPS reimbursement requirements are fully implemented.

Approaches in Other States

States have the option of implementing their CHIP programs though a Medicaid expansion, a separate CHIP, or a combination of the two (as California has chosen to do). According to information from NASHP, a majority of states have chosen over time to utilize contractor-based delivery systems, in which managed care plans provide some or all of the services for CHIP subscribers. MRMIB staff posted questions on CHIP Chat, the all-state on-line listserv for CHIP administrators, requesting information from other states utilizing managed care arrangements on how they currently comply with PPS requirements in their Medicaid programs and how they intend to comply (or are already complying) with this provision in their CHIP programs. To date, MRMIB has received responses from the following states:

- ***Arizona:*** Has a separate CHIP program. Arizona calculates one PPS rate for each FQHC/RHC in both the AHCCCS (Arizona Medicaid) and CHIP programs. The state currently provides wrap-around reconciliation payments to these clinics for services provided to Medicaid subscribers but not for CHIP subscribers.

- ***Delaware:*** Has a combination CHIP program. Delaware requires the MCOs it contracts with to pay FQHCs using the same PPS methodology used under the Medicaid fee-for-service program. The actual rates paid can be greater than the Medicaid fee-for-service rate, but not less. PPS rates are paid whether the services are provided to Medicaid or CHIP subscribers.

- ***Florida****:* Has a combination CHIP program. Florida has enacted legislation to pass the PPS requirement along to the MCOs it contracts with, and to allow MCOs to take this into consideration in their annual rate adjustment requests.

- ***Kentucky**:* Has a combination CHIP program. Kentucky requires the MCOs it contracts with to pay FQHCs/RHCs using the same PPS methodology used under the Medicaid fee-for-service program. However, while the state does an annual reconciliation with clinics for services provided to Medicaid recipients, it does not currently do so for services provided by FQHCs/RHCs to CHIP subscribers.

- ***Minnesota*:** Has a combination CHIP program and utilizes MCOs heavily in providing services to both Medicaid and CHIP subscribers. MCO contracts require them to reimburse FQHCs/RHCs at the same rates paid to other providers, and the state then pays a supplemental amount to each FQHC and RHC. Minnesota already uses the Medicaid PPS rate for CHIP subscribers since the benefit package for both Medicaid and CHIP is the same.

- ***New Mexico:*** Has a Medicaid expansion CHIP program and utilizes managed care contracts with FQHCs/RHCs. New Mexico does a PPS supplemental payment to FQHCs/RHCs for services provided to both Medicaid and CHIP subscribers; rates are essentially the same for both programs as they are based primarily on age and gender.

These responses reveal the individualized approaches states have taken in implementing their CHIP programs and in complying with the PPS requirements in their Medicaid programs. Some states, primarily those with Medicaid expansion CHIP programs, may already be in compliance with the new PPS requirements for their CHIP programs, but for many states, especially those with separate or combination CHIP programs and utilizing a managed care program design like California, the PPS reimbursement approach for CHIP services is entirely new. Given the absence of CMS guidance to date on implementing this requirement, information from other states is likely to change over time as they revise their current reimbursement arrangements to comply with the new PPS requirement.

Effective Date

Complying with CHIPRA Section 503 will require a change in state statute. CHIPRA (Section 3(b)) specifies that provisions requiring a state law change will be effective on "the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment". For California, this effective date is January 1, 2011[2]. For states that do not need state statute change to conform, the effective date is October 1, 2009. (Please see Attachment B for the language of Section 3(b).)

OPTIONS FOR CONSIDERATION

[2] Pending CMS clarification; the implementation date may be later for some MCO requirements.

CHIPRA requires MRMIB to change from the current reimbursement approach for FQHCs/RHCs. The following section highlights the options staff has identified for discussion with the Board.

In evaluating these options, MRMIB staff kept the following criteria in mind:

- ✓ Ease of implementation
- ✓ Efficiency
- ✓ Cost to HFP
- ✓ Incentives
- ✓ Effect on managed care approach
- ✓ Effect on rate negotiations
- ✓ Ease of enforcement

Option 1: Use DHCS to Implement an Approach Similar to Medi-Cal

MRMIB could choose to contract with DHCS to implement the PPS requirements in the same way the state currently implements PPS for the Medi-Cal Program. MRMIB staff has had several conversations with DHCS staff to discuss how this option could be implemented. Medi-Cal staff has provided MRMIB a draft analysis and estimates there would be costs for one-time system modifications, staffing (i.e. additional auditors) and ongoing transaction costs. MRMIB staff is reviewing the analysis and will determine estimated costs if the Board is interested in pursuing this option.

Advantages:

- ✓ *Ease of implementation, efficiency, effect on rate negotiations*, and *ease of enforcement*

  DHCS already has a mechanism in place for implementing the PPS requirements, reimbursing FQHCs/RHCs, and monitoring clinic and MCO compliance. Although there would be implementation issues to resolve, they are relatively minor since DHCS has had several years to develop and refine the PPS reimbursement process. DHCS auditors are familiar with the majority of FQHCs/RHCs, since most of them contract with Medi-Cal; conversely, most clinics are familiar with the reimbursement and reconciliation process developed by Medi-Cal. This option would have no impact on rate negotiations between MRMIB and MCOs.

Disadvantages:

- ✓ *Cost to HFP, incentives,* and *effect on managed care approach*

  MRMIB would be required to reimburse DHCS for their development, implementation and ongoing transaction costs, as well as for staff resources. This approach would

require staff resources to draft and implement an interagency agreement, and to monitor deliverables and compliance with PPS-related activities. This option also shifts the financial relationship between MRMIB and FQHCs/RHCs from a managed care reimbursement approach to a direct, more fee-for-service approach. There may also be some incentive for MCOs to attempt to negotiate lower than average rates with FQHCs/RHCs, knowing that the difference between contracted rates and actual costs would be made up by the "wrap-around" payment. However, this would be a clear violation of statute and contracting requirements.

Option 2: Require MCOs to Implement

MRMIB could opt to re-negotiate the rates paid to MCOs so that the increased reimbursement rates paid to FQHCs/RHCs, and the calculations required to implement the PPS, are passed through to MRMIB in the form of rate increases. The direct costs of implementing the PPS reimbursement approach would then be borne by MCOs contracting with FQHCs/RHCs, and incorporated into the rates paid by MCOs for services provided by these clinics to HFP subscribers.

This is similar to the approach the Florida State Legislature has taken, enacting the following language in state statute: "Effective October 1, 2009, payments for services provided to enrollees by federally qualified health centers and rural health clinics under this section shall be reimbursed using the Medicaid Prospective Payment System as provided for under s. 2107 (e)(1)(d) of the Social Security Act. If such services are paid for by health insurers or health care providers under contract with the Florida Healthy Kids Corporation [Florida's CHIP], such entities are responsible for this payment." (SB 1658, 2009, Enrolled)

Advantages:

- ✓ *Effect on managed care approach*

  Under this option, MCOs would be the entities responsible for calculating the PPS rates for each FQHC/ RHC and reimbursing these clinics for their costs. Once MRMIB re-negotiates the rates with MCOs, the MCOs bear all the financial risks—just as in the current managed care structure of the HFP.

Disadvantages:

- ✓ *Ease of implementation, efficiency, cost to HFP, incentives, effect on rate negotiations,* and *ease of enforcement*

  Implementation and enforcement could actually be a greater burden on MRMIB under this option, since it would require contract re-negotiation and extensive contract monitoring with all the MCOs participating in the HFP. It would be inefficient in that it duplicates the Medi-Cal model and requires MRMIB staff to develop expertise in areas Medi-Cal has already developed.

This option could increase contractual rates significantly—in Florida, rates increased up to 10percent in areas of the state with substantial utilization of FQHCs/RHCs for CHIP services. On the other hand, MCOs in California could refuse to participate if MRMIB insisted on negotiating rate increases deemed insufficient by participating health plans. Additionally, this option could create a disincentive for MCOs to contract with FQHCs/RHCs for services, since the MCOs would bear the financial risk for any miscalculations between the rates they negotiate with MRMIB and the PPS rate they must pay the clinics.

This option would create particular implementation challenges given the use of the Family Value Plans as a core element of the rate negotiation process. MRMIB staff is not at all sure MCOs would be willing to accept the additional financial risks given the state's current fiscal crisis.

Finally, it is unclear whether CMS will approve this approach to complying with the PPS requirements in CHIPRA, since the state does not have direct control over reimbursing FQHCs and RHCs for their costs.

Option 3: Require AV to Implement

MRMIB could choose to contract with the HFP administrative vendor (AV) to develop and implement the process for reimbursing FQHCs/RHCs and calculating the PPS rate. The AV could then reconcile, once a year, between the interim reimbursement rates and the actual PPS rate, and conduct the requisite audits. This option is similar to Option 1, except that instead of using the Medi-Cal model, MRMIB would contract with the HFP AV for implementation, oversight and enforcement of the PPS reimbursement approach.

***Advantages**:*

- ✓ *Cost to HFP* and *effect on rate negotiations*

  MRMIB would re-create the Medi-Cal model with the HFP AV. Experience has demonstrated that including tasks in the AV contract has been cost effective and provides opportunities to include performance standards, etc. Additionally, this option would have no negative effect on rate negotiations between MRMIB and MCOs participating in the program.

Disadvantages:

- ✓ *Ease of implementation, efficiency, incentives, effect on managed care,* and *ease of enforcement*

  This option appears to present most of the disadvantages present in the first two options. MRMIB would be required to reimburse the AV for their development, implementation and ongoing transaction costs. This approach would require staff

resources to draft and implement a contract amendment with the AV, and to monitor deliverables and compliance with PPS-related activities. This option also shifts the financial relationship between MRMIB (through the AV) and FQHCs/RHCs from a managed care reimbursement approach to a direct, more fee-for-service approach. As in Option 1, there may also be some incentive for MCOs to attempt to negotiate lower than average rates with FQHCs/RHCs, knowing that the difference between contracted rates and actual costs would be made up by the "wrap-around" payment. However, this would be a clear violation of statute and contracting requirements. This option would also be inefficient in that it duplicates the Medi-Cal model and requires both MRMIB and the AV staff to develop expertise in areas Medi-Cal has already developed.

The advantages of each of these options are summarized in the table below.

CRITERIA:	**OPTION 1: Medi-Cal to Implement**	**OPTION 2: MCOs to Implement**	**OPTION 3: AV to Implement**
Ease of implementation	✓		
Efficiency	✓		
Cost to HFP			✓
Incentives			
Effect on managed care approach		✓	
Effect on rate negotiations	✓		✓
Ease of enforcement	✓		

✓ = Advantage of this option

SUMMARY

This issue brief has identified the options for complying with federal CHIPRA requirements to reimburse FQHCs/RHCs using the PPS reimbursement approach. Based on a review of the

advantages and disadvantages of the options described above, MRMIB staff recommends Option 1, the Medi-Cal-like approach, as the best option to pursue in discussions with the Administration, state Legislature, and stakeholders regarding implementing the CHIPRA PPS requirement.

If the Board feels it has sufficient information to select this as a preferred option, MRMIB staff further recommends that the Board direct it to develop an implementation approach in more detail for this option.

If the Board feels that more information is needed in order to identify a preferred option, MRMIB staff recommends that specific questions be discussed so that staff may return to the Board with information that will assist the Board in selecting a preferred option.

H.R.2

Children's Health Insurance Program Reauthorization Act of 2009
(Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 503. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) Application of Prospective Payment System

(1) IN GENERAL- Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 501(c)(2) is amended by inserting after subparagraph (C) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

(D) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).

(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to services provided on or after October 1, 2009.

(b) Transition Grants

(1) APPROPRIATION- Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2009, $5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of the Social Security Act (including any waiver of such plan), or in combination with the State Medicaid plan, for expenditures related to transitioning to compliance with the requirement of section 2107(e)(1)(D) of the Social Security Act (as added by subsection (a)) to apply the prospective payment system established under section 1902(bb) of the such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

(2) MONITORING AND REPORT- The Secretary shall monitor the impact of the application of such prospective payment system on the States described in paragraph (1) and, not later than October 1, 2011, shall report to Congress on any effect on access to benefits, provider payment rates, or scope of benefits offered by such States as a result of the application of such payment system.

H.R.2

Children's Health Insurance Program Reauthorization Act of 2009
(Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 3. GENERAL EFFECTIVE DATE; EXCEPTION FOR STATE LEGISLATION; CONTINGENT EFFECTIVE DATE; RELIANCE ON LAW.

(a) General Effective Date.--Unless otherwise provided in this Act, subject to subsections (b) through (d), this Act (and the amendments made by this Act) shall take effect on April 1, 2009, and shall apply to child health assistance and medical assistance provided on or after that date.

(b) Exception for State Legislation.--In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(c) Coordination of CHIP Funding for Fiscal Year 2009.--Notwithstanding any other provision of law, insofar as funds have been appropriated under section 2104(a)(11), 2104(k), or 2104(l) of the Social Security Act, as amended by section 201 of Public Law 110-173, to provide allotments to States under CHIP for fiscal year 2009—

(1) any amounts that are so appropriated that are not so allotted and obligated before April 1, 2009 are rescinded; and

(2) any amount provided for CHIP allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

Medi-Cal Implementation of PPS Supplemental Payments in Managed Care Counties
Welfare and Institutions Code Sections 14087.325 and 14132.100-14132.107

14087.325. (a) The department shall require, as a condition of obtaining a contract with the department, that any local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California **Code** of Regulations, offer a subcontract to any entity defined in Section 1396d(l)(2)(B) of Title 42 of the United States **Code** providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States **Code** and operating in the service area covered by the local initiative's contract with the department. These entities are also known as federally qualified health centers.

(b) Except as otherwise provided in this section, managed care subcontracts offered to a federally qualified health center or a rural health clinic, as defined in Section 1396d(l)(1) of Title 42 of the United States **Code**, by a local initiative, county organized health system, as defined in Section 12693.05 of the Insurance **Code**, commercial plan, as defined in subdivision (h) of Section 53810 of Title 22 of the California **Code** of Regulations, or a health plan contracting with a geographic managed care program, as defined in subdivision (g) of Section 53902 of Title 22 of the California **Code** of Regulations, shall be on the same terms and conditions offered to other subcontractors providing a similar scope of service. Any beneficiary, subscriber, or enrollee of a program or plan who affirmatively selects, or is assigned by default to, a federally qualified health center or rural health clinic under the terms of a contract between a plan, government program, or any subcontractor of a plan or program, and a federally qualified health center or rural health clinic, shall be assigned directly to the federally qualified health center or rural health clinic, and not to any individual provider performing services on behalf of the federally qualified health center or rural health clinic.

(c) The department shall provide incentives in the competitive application process described in paragraph (1) of subdivision (b) of Section 53800 of Title 22 of the California **Code** of Regulations, to encourage potential commercial plans as defined in subdivision (h) of Section 53810 of Title 22 of the California **Code** of Regulations to offer subcontracts to these federally qualified health centers.

(d) Reimbursement to federally qualified health centers and rural health centers for services provided pursuant to a subcontract with a local initiative, a commercial plan, geographic managed care program health plan, or a county organized health system, shall be paid in a manner that is not less than the level and amount of payment that the plan would make for the same scope of services if the services were furnished by a provider that is not a federally qualified health center or rural health clinic.

(e) (1) The department shall administer a program to ensure that total payments to federally qualified health centers and rural health clinics operating as managed care subcontractors pursuant to subdivision (d) comply with applicable federal law pursuant to Sections 1902(aa) and 1903(m)(2)(A)(ix) of the Social Security Act

(42 U.S.C.A. Secs. 1396a(aa) and 1396b(m)(2)(A)(ix)). Under the department's program, federally qualified health centers and rural health clinics subcontracting with local initiatives, commercial plans, county organized health systems, and geographic managed care program health plans shall seek supplemental reimbursement from the department through a per visit fee-for-service billing system utilizing the state's Medi-Cal fee-for-service claims processing system contractor. To carry out this per visit payment process, each federally qualified health system and rural health clinic shall submit to the department for approval a rate differential calculated to reflect the amount necessary to reimburse the federally qualified health center or rural health clinic for the difference between the payment the center or clinic received from the managed care health plan and either the interim rate established by the department based on the center's or clinic's reasonable cost or the center's or clinic's prospective payment rate. The department shall adjust the computed rate differential as it deems necessary to minimize the difference between the center's or clinic's revenue from the plan and the center's or clinic's cost-based reimbursement or the center's or clinic's prospective payment rate.

(2) In addition, to the extent feasible, within six months of the end of the center's or clinic's fiscal year, the department shall perform an annual reconciliation to reasonable cost, and make payments to, or obtain a recovery from, the center or clinic.

(f) In calculating the capitation rates to be paid to local initiatives, commercial plans, geographic managed care program health plans, and county organized health systems, the department shall not include the additional dollar amount applicable to cost-based reimbursement that would otherwise be paid, absent cost-based reimbursement, to federally qualified health centers and rural health clinics in the Medi-Cal fee-for-service program.

(g) On or before September 30, 2002, the director shall conduct a study of the actual and projected impact of the transition from a cost-based reimbursement system to a prospective payment system for federally qualified health centers and rural health clinics. In conducting the study, the director shall evaluate the extent to which the prospective payment system stimulates expansion of services, including new facilities to expand capacity of the centers, and the extent to which actual and estimated prospective payment rates of federally qualified health centers and rural health clinics for the first five years of the prospective payment system are reflective of the cost of providing services to Medi-Cal beneficiaries. Clinics may submit cost reporting information to the department to provide data for the study.

(h) The department shall approve all contracts between federally qualified health centers or rural health clinics and any local initiative, commercial plan, geographic managed care program health plan, or county organized health system in order to ensure compliance with this section.

(i) This section shall not preclude the department from establishing pilot programs pursuant to Section **14087**.329.

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1, thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the **Code** of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a

scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the **Code** of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due

to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (l). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter

between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice.

(B) Notwithstanding subdivision (e), an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice for the purposes of establishing its FQHC or RHC rate shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist or dental hygienist in alternative practice services, and later elects to add these services, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare Program, or the Child Health and Disability Prevention (CHDP) program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall

establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis until it is informed of its enrollment as an FQHC or RHC, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-services adjustments as provided

in subdivision (e).

(l) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, by no later than March 30, 2008, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

14132.101. (a) Notwithstanding paragraphs (4) and (5) of subdivision (e) of Section 14132.100, a scope-of-service change request, whether mandatory or permissive, shall be timely when filed within 150 days following the beginning of the federally qualified health center's or rural health clinic's fiscal year following the year in which the change occurred.

(b) Notwithstanding subdivision (a), and notwithstanding subdivision (e) of Section 14132.100, a federally qualified health center described in Section 14132.102 shall be deemed to have filed a scope-of-service change in a timely manner upon compliance with the requirements set forth in subdivision (c) of Section 14132.102.

14132.102. (a) With the exception of clinics and hospital outpatient departments that are subject to Section 14105.24, federally qualified health centers (FQHCs) that are receiving cost-based reimbursement under the terms of the Los Angeles County 1115 Waiver Demonstration Project on June 30, 2005, shall be required to transition to a prospective payment system (PPS) rate upon expiration of that waiver. These FQHCs shall be referred to in this section as "Los Angeles cost-based FQHCs."

(b) For visits occurring on or after July 1, 2005, Los Angeles cost-based FQHCs shall receive a PPS rate equivalent to the following:

(1) FQHC sites that were in existence during the FQHC's 2000 fiscal year shall be permitted to elect their 2000 per-visit rates or the average of the 1999 and 2000 per-visit rates as reported on the cost reports submitted for those fiscal years adjusted as described in subdivision (c).

(2) FQHC sites that were first qualified as an FQHC after the site's 2000 fiscal year shall receive a base rate equivalent to the first full fiscal year rate, as audited on the cost report submitted for that fiscal year and adjusted as described in subdivision (c).

(3) Sites that were first qualified as an FQHC after the site's 2000 fiscal year, and that have not yet filed a cost report for their first full fiscal year shall have a rate set in accordance with subdivision (i) of Section 14132.100 and adjusted as described in

subdivision (c).

(c) The base rates described in this section shall be adjusted in the manner described in subdivision (d), paragraphs (1), (2), (3), and (7) of subdivision (e), and subdivision (f) of Section 14132.100.

(d) For Los Angeles cost-based FQHCs, as defined in subdivision (a), no new cost reports shall be required in order to claim scope-of-service changes occurring in fiscal years prior to July 1, 2005. Only the following information shall be required by the department:

(1) A description of the events triggering any applicable rate changes in the form of Worksheet 1 of the Change in Scope-of-Service Request form developed for fiscal years 2004 and thereafter, modified to identify the applicable fiscal year in which the scope change occurred.

(2) The two worksheets to the Change in Scope-of-Service Request form summarizing the health center's health care practitioners and services for the applicable fiscal year or years.

(e) Change in Scope-of-Service Request forms for changes occurring prior to July 1, 2005, shall be filed with the department no later than July 1, 2006, and shall be deemed to have been filed only when both the Medi-Cal cost report for the applicable period and the referenced Change in Scope-of-Service Request form worksheets have been filed with the department. The date of filing shall be the date on which either the Medi-Cal cost report or the referenced Change in Scope-of-Service Request forms are received by the department, whichever is later.

(f) Notwithstanding Section 14132.107, the department shall calculate a tentative scope-of-service rate adjustment based on 80 percent of the difference in the "as reported" scope-of-service per visit cost. This adjustment shall occur no later than 150 days after receipt of the Medi-Cal cost report and the referenced Change in Scope-of-Service Request forms. Within 12 months after receipt of request forms, the department shall complete its FQHC fiscal year audit of the Medi-Cal cost report and associated Change in Scope-of-Service Request and final rate adjustment pursuant to that audit. The final rate adjustment will be retroactive to July 1, 2005. Nothing in this subdivision shall be construed to extend the time period for review and finalization of cost reports as set forth in Section 14170.

(g) The department shall, by no later than March 30, 2006, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and only to the extent that all necessary federal approvals are obtained and there is an appropriation for the purposes of implementing this section, the department may implement this section without taking any regulatory action and by means of a provider bulletin or similar instructions.

14132.107. Claims for reimbursement under subdivision (e) of Section 14132.100 shall be finalized by the department within 150 days of receipt of the claims for reimbursement. These claims for reimbursement shall be paid within 30 days of being finalized by the department. However, the payment of those amounts that are disputed shall be subject to the requirements, timeframes, and procedures specified in Section 14171. Scope changes going forward shall be finalized within 90 days of receipt and paid within 30 days of being finalized by the department.